UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

CEREZYME (imiglucerase)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA

- **DOCUMENTED** diagnosis of **Gaucher's Disease**
- Copy of prescription from physician
- Medicaid must be notified of changes in dosage with a copy of a new prescription.

AUTHORIZATION:

6 months.

RE-AUTHORIZATION:

1 year with documentation of significant improvement

7/7/6